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EDITORIAL

What would you do if he were your father? The benefits of empathetic oncologist-patient communication

¿Qué harías si fuera tu padre? Los beneficios de la comunicación empática oncólogo-paciente

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The need for specific training in communication… We talk about it, but we do not do it

Few professions have such extremely long training periods as oncology. And, undoubtedly, the raw material with which it deals requires this. Among the competencies established in the training program for the specialty of medical oncology,[1] "human clinical communication" appears as one of the most important. But one thing is what the law says, and another is reality. As a tutor of doctors in training, I always encountered the same difficulty when evaluating this knowledge. Just as we have tools to objectify the skills acquired in the other competencies – courses, articles or conference presentations, a minimum number of visits for certain conditions, language level – we do not have regulated tools to teach and assess communication skills.[2] We have few clinical guidelines that teach us how to do this.[3] Not even at university is there a specific subject on communication. Communication that will be the backbone of the entire doctor-patient relationship. Communication that, if correct, will become the rail along which a fluid and effective relationship travels. But if incorrect, it will become a permanent source of detachment and misunderstandings.

This self-taught learning of communication skills, in which each person combines their personal qualities with the mimicry learned from senior colleagues – with their great virtues and their equally great flaws and routines – with their own experience and intuitions, is clearly insufficient. And when we speak of communication, we are not speaking of just any communication, but of empathic communication. And yes, communication and empathy can be learned, cultivated, and strengthened. How?

What would you do if he were your father?

I remember a patient from when I was a novice oncologist who, although not an especially complex case, gave me much to think about. I had just finished my training period and was holding consultations in a district hospital. I was seeing a 79-year-old man with diabetes and previous well-controlled ischaemic heart disease. He had just been diagnosed with advanced lung cancer: squamous cell carcinoma with liver and adrenal metastases. Although the disease seemed to be behaving very aggressively, the man maintained an excellent general condition. He was a man from the countryside and lived in a village in one of the most beautiful valleys of the Western Pyrenees. Although he had given up farm work years earlier, he still went every day to his vegetable garden, one of his passions. His other passions were long walks in the mountains and, of course, his family. Reaching our hospital took him more than an hour by car, along a road that was not in

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very good condition. And that was without considering that, in winter, the journey often became impracticable. And it was December.

During our first consultation, which he attended with his wife and 2 of his 4 daughters, I explained the diagnosis, the stage, the prognosis of the disease, and treatment options. At that time, clinical practice guidelines indicated that the best therapeutic option was a platinum doublet. “What is that?” they asked. Of course, there we already have one of the first barriers to empathic communication. Any oncologist knows what scenario we are dealing with as soon as they hear the expression “platinum doublet.” Yet this expression is completely bewildering to anyone outside our world, and may sound more like recognition of a famous singer’s musical career than an anticancer therapeutic strategy. We make this mistake, communicating while assuming prior knowledge, far too often.

I explained to them that a platinum doublet is chemotherapy that combines 2 antitumor drugs, one of which is derived from the chemical compound platinum. In both cases, it is intravenous medication that requires the patient to attend hospital every 21 days, with blood tests performed the day before. The treatment exposes the patient to considerable toxicity, which very often has a strong impact on quality of life. In stage IV disease, as in this case, the aim of oncological treatments is not cure, but improvement of quality of life and, secondarily, if the first aim is achieved, increased survival. Platinum doublets, therefore, do not cure. They improve symptoms on some occasions and achieve a median survival of < 12 months. Overall, they provide a few more months of life compared with no treatment. And in our patient, at that point, there were few symptoms to relieve, because he had practically none. It is also true that, although median survival was < 12 months, a small group of patients derive greater benefit and may prolong their lives, even for years, in good condition.

With this massive amount of information, which is usually what occurs the first time contact is made with oncology, the normal reaction, as happened in this case, is for the patient and those accompanying him to feel stunned. There are too many new things in just a few minutes and, on top of that, often with the urgency of making decisions. In this state of bewilderment that I detected in the family, one of the daughters, who was also 5 months pregnant, asked me a question. I had probably been asked it many more times, but on this occasion it affected me in a special way: “What would you do if he were your father?”

My father, who was somewhat younger than my patient, had died just 2 months earlier. It had not been from cancer but from a cerebral hemorrhage, which, after emergency surgery and a few days in the intensive care unit, had not gone well. Then too, we had had to decide whether to disconnect him from the ventilator or keep him on it for an unknown length of time, but without any possibility of the situation becoming reversible. And we had to decide under conditions of great emotional burden.

One of the great achievements of our specialty is that of progressively ordering and classifying the ever-growing knowledge of the disease we seek to combat. Everything is highly protocolized and standardized: tumor classifications, stages, assessment and measurement of responses to treatment, grading of all possible toxicity and adverse effects. It is a common global oncological language that seeks to objectify as much as possible and is the basis for the solid advances made in the fight against cancer. Clinical practice guidelines and decision-making algorithms take into consideration multiple clinical, analytical, molecular, and genetic parameters.

Tet clinical practice guidelines do not take into consideration whether the patient wants to continue going to his vegetable garden or not. Whether, to come down to see us, they have to put snow chains on the car because snow is very common at that time of year. Whether he wants to live to see his fifth grandchild born or squeeze a little more life out of life to see his first granddaughter receive her First Communion.

That is why, beyond the essential clinical practice guidelines, the question “What would you do if he were your father… your mother, your brother, your daughter?” is highly pertinent. And since then, for me, it has been a yardstick, an important aid in communication with patients and their relatives, especially in situations where decisions are not easy. It is a question I ask myself often, and it helps me above all in those moments in which decisions in medicine are not clearly black or white.

Difficulties and challenges for empathic communication in day-to-day consultations

On a normal day, I see an average of 20 patients in my lung cancer and thoracic tumors clinic. One quarter of them are patients to whom I have to say that their disease has worsened. And of those 20, 1 or 2 are first visits: recently diagnosed patients attending the oncologist for the first time. For them, this may be the

most important moment of the year, of the decade. Certainly, most of the time, it is a turning point in life that will drastically change their present and their future. For me, it is the 5th, 6th, or 7th time that day that I give news no one wants to hear. The emotional distance between the 2 sides of the desk is an abyss. With all due differences, I remember when I went with my wife to the first ultrasound scan of my first child. I was a bundle of nerves, and the gynecologist, looking at the screen while passing the ultrasound probe over my wife's abdomen, dictated to the assistant who was taking notes: "one… alive…." For us, it was our first child. A unique moment. For the gynecologist, it was the umpteenth ultrasound of the day in which there was an embryo – not 2 or 3 – and it had a heartbeat. I remember every instant of that moment and the gynecologist's full name. He, logically, does not remember it at all.

And this must be borne very much in mind. What we say in consultations, and especially during first visits, is often etched into the patient and their family. That first visit is key to the relationship of trust between healthcare professional and patient. That immense emotional distance must be taken into consideration and consciously acknowledged to avoid falling into routines, clichés, and insensitivities. Patients often remember every word you say to them. Many, if things later go well, remember the date of diagnosis as a second birth.

Using "as if he were your father" as a yardstick helps us empathize. But he is not your father. And he must not be. The emotional distance that separates us can and should be beneficial. At those moments when the patient and their family are in a state of shock, overwhelmed by a whirlwind of emotions, someone must remain calm. Our role is to show, with the greatest warmth and understanding, the objectivity of the facts. Empathizing does not mean becoming emotionally involved, because then we would lose the role that the patient most needs. In a sea stirred by the storm, the patient and their family seek a safe harbor to which they can moor, even temporarily to continue the next leg of the voyage. There have been more than a few occasions when I have felt like crying in front of a patient. And on some of them, I have even had to leave the consultation room with some excuse so that I could let it out. But I believe my tears would not have helped at all.

The balance is not easy. But therein lies the great challenge of our profession. Like the flight of Daedalus. To fly between the risk of creating an emotional shell that seems to protect us, but at the same time desensitizes us and makes empathic communication impossible, and the risk of becoming excessively emotionally involved, losing the effectiveness of our actions and putting ourselves in danger of burning our wings too soon.

One of the great achievements of our health care system, and one of those of which professionals and users feel most proud, is the extensive and effective universalization of its services. One of its great challenges, where much remains to be done, is the individualization and humanization of its services.

I acknowledge that the physical and temporal structure of hospital consultations does not help empathic communication. The fact is that we are so used to it, and oncology patients are so patient, that we tend not to give it the importance it deserves. The hospital structure is functional and efficient, but it is far from friendly to empathic communication. Overcrowded waiting rooms, with hardly any elements that allow attention to focus on something pleasant. Small, aseptic consultation rooms, without decorative elements, with desks and computers acting as an insurmountable barrier between doctor and patient. Many people in white coats or green scrubs entering and leaving, generally in a hurry, with papers, telephones, and computers. If we were to dream, we might imagine waiting rooms with armchairs and sofas, decorated with pleasant motifs, soft and relaxing background music, and reading areas with coffee or herbal teas. Consultation rooms without desks, without physical barriers between doctor and patient. And, even more importantly, sufficiently long appointments to be able to dedicate enough time to each person. The tyranny of the "quarter of an hour" per patient imposed by the appointment system is a pressure that greatly constrains us when trying to communicate effectively. Many times, much to our regret, the consultation is a race against the clock. After the dialogue with the patient comes the next patient, who usually already enters with some accumulated delay. And after finishing, there is usually bureaucratic work involving reports, validations, and confirmations, which requires practically the same amount of time as that spent facing the "public."

The structure is not designed for empathic communication. Adapting it to this would undoubtedly require greater allocation of resources. Resources that are scarce most of the time. And yet these shortcomings are often compensated for by the great humanity and dedication of the professionals involved, both health care and non-healthcare professionals. The important work carried out by patient and volunteer associations

aimed at humanizing health care structures should also be highlighted here. This is a field with much room for improvement.

Conclusion: listening, listening, and trust as the basis of effective communication

An elderly woman diagnosed with very extensive breast cancer once came to the consultation. When I went to examine her, I saw that her right breast was missing and asked her when she had had surgery. "I have not had surgery, doctor, I swear." Faced with my insistence, because all I could see was the ulcerated rib cage with no breast, she repeated 3 times that she had not had surgery. In disbelief, I reviewed her medical history and, indeed, she had never been operated on. The tumor had eaten away her right breast until it disappeared! And now it was already affecting the ribs, pleura, and lungs. "Madam! And how long have you noticed this?" She told me that she had noticed a lump more than 5 years earlier and that, little by little, it had grown, ulcerated, and retracted the breast. She had never visited a doctor. Not even her daughters knew. When, in my insensitivity, I reproached her for this, she burst into tears and told me that they had just buried her husband, who had been bedridden for years because of a long illness; that 4 years earlier, a daughter had died of leukemia; and that she had another daughter with a serious psychiatric problem. That woman had subordinated all her pain and illness to sustaining her family. Undoubtedly, I had judged before listening.

Listening is the main tool oncologists have for an empathic relationship. Listening is the cornerstone of the rest of the communicative structure. And listening is not only hearing what the patient tells me with words. Listening means looking beyond. Seeing what patients tell us with their gestures, their attitudes, and their non-verbal language. Assessing their context, scrutinizing their biography. Over these years, I have learned that apparently irrelevant conversations are key to "listening" better to the patient and establishing much-needed bonds of trust. How often conversations with patients about their profession, their village, their hobbies, their hopes, and their family, in addition to being small oases in the middle of the desert, generate fertile ground for that much-needed empathic communication. Yes, I believe we must seek spaces for active listening. For meaningful conversations… and for meaningless ones.

Active listening must also be shown through our own attitude and our own language, both verbal and non-verbal. The first medical act is to introduce oneself. When a patient walks through the door, in addition to finding an orderly, warm, open space that allows direct eye contact, the patient must know with whom they are about to entrust their life. We should introduce ourselves with our first name, surname, and position in the unit. We should introduce the nurse, the nursing assistant, the resident physician, and the student, if there is one. How many times does a patient enter a consultation room and find 2 or 3 people there without knowing who those people are with whom they are about to discuss the most important things in life?

Listening requires full attention. Leaving the telephone switched off in a drawer while we are with the patient in the consultation room. The patient must feel that, at that moment, their matters are the most important. Interruptions should be avoided once the dialogue has begun. Reinforcing, paraphrasing, repeating, summarizing, or underlining part of the information provided by the patient are ways of showing active listening, and they can be cultivated and practiced just as communication experts teach us. They call it the mirror technique.

Listening means not judging. When I was younger, I used to be more vehement in the speeches I gave to patients who continued to smoke or to those who missed an appointment. I realized that moralizing lectures are of little use. Who are we to know the reasons why that patient had lit another cigarette? Who are we to know the fear that a worker in precarious conditions has of taking that day off to go to the doctor, because doing so might put their job at risk? Each patient is a world, and what cannot be achieved through the suggestion born of empathic communication will not be achieved through moralistic scolding.

References

1. Boletín Oficial del Estado. Orden SS/577/2013 de 5 abril, por la que aprueba y publica el programa formativo de la especialidad de Oncología Médica y los criterios de evaluación de los especialistas en formación [Internet]. España: Agencia Estatal Boletín Oficial del Estado; 2013. Available at: https://www.boe.es/eli/es/o/2013/04/05/ssi577
2. Sociedad Española de Oncología Médica. Guía para la implementación del POE de Oncología Médica [Internet]. SEOM; 2014. Available at: https://seom.org/seomcms/images/stories/recursos/DOCUMENTO_masMIR.pdf
3. Stiefel F, Bourquin C, Salmon P, Achtari Jeanneret L, Dauchy S, Ernstmann N, et al. Communication and support of patients and caregivers in chronic cancer care: ESMO Clinical Practice Guideline. ESMO Open. 2024;9(7):103496.